

USAF Refractive Surgery (USAF-RS)
Managed Care Agreement for Civilian Treatment
(to be completed by patient and co-managing provider)

Patient Name

Rank

Service / Status

Military Installation

Phone Number

☐ YES ☐ NO if YES, when _____
Upcoming PCS/Separation/Retirement/Deployment

Refractive Surgery Center (Name and Address)

PATIENT AGREEMENT

_____ I understand that I must comply with and accomplish all required referral and follow-up evaluations as required by USAF policy. Non-compliance may result in duty restrictions or disqualification.

_____ I understand that by electing to receive civilian treatment, the surgery and follow-up evaluations will be provided by the civilian refractive surgery center at my own expense.

_____ I will contact my local Optometry Clinic or Primary Care Manager within 3 days of receiving treatment to initiate a Duty Limiting Condition report.

_____ I am aware that I will be placed on Duty Limiting Condition status after surgery and can not deploy or PCS for up to 4 months after surgery. I understand that I must be evaluated by the base optometry clinic prior to being cleared to resume unrestricted duties.

_____ I understand that I must bring a copy of all pre-operative evaluations, surgical reports, and follow-up exams performed by the civilian Refractive Surgery Center for inclusion in my military medical records.

Patient Signature

Date

CO-MANAGING PROVIDER'S AGREEMENT

_____ I certify that I will manage this patient and accept responsibility for his/her post-operative care. Post-operative appointments will be scheduled at 1 day, 1 week, and 1, 3, 6, and 12 months. If a surface procedure (PRK, LASEK, or Epi-LASIK) is performed, a 2 months intraocular pressure check will be also required.

_____ I will provide a copy of all pre-operative evaluations, surgery reports, and follow-up exams performed to the patient for inclusion into his/her military medical records.

_____ I will immediately refer the patient to the base optometry clinic if visual acuity is not correctable to 20/40 or better at the 3, 6, or 12-month appointments.

Refractive Surgeon Name/Signature

Date

Phone

Fax